Transparency in Coverage

QHP and QDP Issuers are required to provide an active and current URL where consumers can view pertinent information about an issuer's claims payment policies and practices. The information below provides an overview and examples of the information that must be included on the URL webpage:

1. **Out-of-network liability and balance billing**
   - Description:
     - Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or the amount remaining on a deductible.
   - Provide:
     - Information regarding whether a consumer may have financial liability for out-of-network services.
     - Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act.
     - Information regarding whether a consumer may be balance billed. You do not need to include specific dollar amounts for out-of-network liability or balance billing.

Example of Acceptable Consumer-Facing Language: Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out of-network facility.

2. **Enrollee claim submission**
   - Description:
     - An enrollee submits a claim instead of the provider, requesting payment for services received.
   - Provide:
     - General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, indicate this here.
     - A time limit to submit a claim, if applicable. If your time limits vary by state, list out the states and their corresponding time limits.
     - Links to any applicable forms. All forms must be easily identifiable and publicly accessible.
     - Describe how an enrollee can submit a claim if you do not require any forms. List any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission.
     - The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number.

Example of Acceptable Consumer-Facing Language:
A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. There are time limits on how long

you have to submit claims, with details on the limit by state below. You can also check your specific plan's claims filing time limit information to determine the specific time limit for submitting your claim.
Enrollee medical claim submission and claim filing time limit information:
State (Maximum Claim Filing Time Limit) for CA is 90 Days

To file a claim, follow these steps:
1) Complete a claim form **[Include link to Claim Form].].**
2) Attach an itemized bill from the provider for the covered service.
3) Make a copy for your records.
4) Mail your claim to the address below.
   [Company Name]
   [P.O Box 1234]
   [City, State, ZIP Code]
5) Alternatively, you can send the information by email to [claims-submissions@companyname.com] or by fax to [123-456-7890].

3. Grace periods and claims pending

- Description:
  - If you are a QHP issuer, you must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, you must provide an explanation of the 90-day grace period for enrollees with premium tax credits, pursuant to 45 CFR 156.270(d).
- Provide:
  - An explanation of what a grace period is.
  - An explanation of what claims pending is.
  - An explanation that you will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

Example of Acceptable Consumer-Facing Language:
You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in [state], we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.
If you are enrolled in an individual health care plan offered through Covered California and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered

services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

4. Retroactive denials

- Description:
  - A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment.
- Provide:
  - An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
  - Ways to prevent retroactive denials when possible, such as paying premiums on time.

Example of Acceptable Consumer-Facing Language:
A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.
You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

5. Recoupment of overpayments

- Description:
  - If you overbill an enrollee for a premium, they may use recoupment of overpayments to obtain a refund.
- Provide:
  - Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact.

Example of Acceptable Consumer-Facing Language:
If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.

6. Medical necessity and prior authorization timeframes and enrollee responsibilities

- Description:
  - Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.
  - Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit.
- Provide:
  - An explanation that some services may require prior authorization and may be subject to review for medical necessity.
  - Any ramifications should the enrollee not follow proper prior authorization procedures.
  - A timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable.

Example of Acceptable Consumer-Facing Language:
We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll.
We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.

7. Drug exception timeframes and enrollee responsibilities (not required for SADPs)

- Description:
  - Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).
- Provide:
  - An explanation of the internal exceptions process for people to obtain non-formulary drugs.
  - An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or Independent Review Organization (IRO).
  - Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact.

Example of Acceptable Consumer-Facing Language:
Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form [link provided here]. If the drug is denied, you have the right to an external review.
If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision.
An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:
[Request Form Link]
[Address]
[Phone]
[Fax]
For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request.
For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request.
For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request.

For external review of expedited exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.

8. Explanation of benefits (EOB)

- Description:
  - An EOB is a statement you send an enrollee that lists the medical treatments or services you paid for on an enrollee's behalf, what you paid, and the enrollee's financial responsibility pursuant to the terms of the policy.
- Provide:
  - An explanation of what an EOB is.
  - Information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims).
  - How a consumer should read and understand the EOB

Example of Acceptable Consumer-Facing Language:
Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form.
The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.

9. Coordination of benefits (COB)

- Description:
  - COB allows an enrollee who is covered by more than one plan to determine which plan pays first.
- Provide:
  - An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

Example of Acceptable Consumer-Facing Language:

- Coordination of benefits, or COB, is required when you are covered under one or more additional group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about COB can be found in your benefit booklet.